Coding Pitfalls

2013-2014 NAACCR Webinar Series

September 11, 2014

Q&A

- Please submit all questions concerning webinar content through the Q&A panel.
  
  Reminder:
  
  - If you have participants watching this webinar at your site, please collect their names and emails.
    
    - We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

Fabulous Prizes
Resources and Requirements

- Collaborative Stage Data Collection System (CS)
  - V02.05 effective for cases diagnosed 1/1/2014 thru 12/31/2015
  - Required by CoC, CDC NPCR, and NCI SEER for cases diagnosed in 2014 and 2015

- AJCC TNM Stage
  - AJCC Cancer Staging Manual 7th Edition
    - CoC continues to require TNM stage
    - CDC NPCR
      - 1/1/2014 Requires directly coded TNM as available from CoC providers
      - 1/1/2015 Requires directly coded TNM from CoC providers and may be as available from small providers
      - 1/1/2016 Requires directly coded TNM
    - NCI SEER
      - 1/1/2015 Requests directly coded TNM as available
      - 1/1/2016 Requires directly coded TNM

- AJCC TNM Stage
  - AJCC Cancer Staging Manual 8th Edition
    - 10/1/2016 Scheduled publication
    - 1/1/2017 Scheduled implementation
Resources and Requirements

- Summary Stage 2000
  - CDC NPCR
    - 1/1/2015 Requires directly coded Summary Stage 2000
  - NCI SEER
    - 1/1/2016 Requires directly coded Summary Stage 2000

Resources and Requirements

- Multiple Primary and Histology (MP/H) Coding Rules
  - Revised 8/24/2012
  - Revision tentatively planned for 1/1/2016 implementation
- Hematopoietic and Lymphoid Neoplasm Database and Coding Manual
  - Revised 1/17/2014
  - Provides data collection rules for 2010 forward

Resources and Requirements

- SEER*Rx Interactive Antineoplastic Drugs Database (SEER*Rx)
  - Updated 8/6/2013
- SEER Program Coding & Staging Manual 2014
  - Released 7/2/2014
  - Effective for cased diagnosed 1/1/2014 and forward
Resources and Requirements

- FORDS 2013
  - Release of FORDS major revision tentatively scheduled for 1/1/2017
- CoC Cancer Program Standards 2012: Ensuring Patient-Centered Care

Resources and Requirements

- Standards for Cancer Registries Volume II: Data Standards & Data Dictionary
  - Version 14: Implemented 1/1/2014
  - Version 15: Scheduled for implementation 1/1/2015
  - Version 16: Scheduled for implementation 1/1/2016
  - Version 17: Scheduled for implementation 1/1/2017
  - Version 18: Scheduled for implementation 1/1/2018

Resources and Requirements

- ICD-O-3
  - 2014 and 2015
    - Guidelines for ICD-O-3 Implementation
      - [http://www.naaccr.org/LinkClick.aspx?fileticket=u7C3dR7715wx%3d&tabid=1292&mid=62654](http://www.naaccr.org/LinkClick.aspx?fileticket=u7C3dR7715wx%3d&tabid=1292&mid=62654)
    - 1/1/2016 ICD-O-3.1 tentatively scheduled for North American implementation
    - Online version
      - ICD-O-3 (2000)
      - ICD-O-3.1 (2011)
Where to Send Questions

**CAnswer Forum**
- AJCC TNM Staging
- Collaborative Stage
- FORDS/NCDB
- 2012 CoC Cancer Program Standards
- [http://cancerbulletin.facs.org/forums/content.php](http://cancerbulletin.facs.org/forums/content.php)

**Ask a SEER Registrar**
- Multiple Primary & Histology Coding Rules
- Hematopoietic & Lymphoid Neoplasm Database and Coding Manual
- SEER*Rx Interactive Antineoplastic Drugs Database
- ICD-0-3, ICD-10-CM, ICD-9-CM
- SEER Coding & Staging Manuals
- [http://seer.cancer.gov/registrars/contact.html](http://seer.cancer.gov/registrars/contact.html)

Grade

- Revised instructions
  - Are applicable for cases diagnosed 1/1/2014 and forward
Grade

- Q: Is there going to be a change to Gleason 7, which is now = grade 3?
  - A: I’ve heard it will change to grade 2, MOD DIFF.

- Q: Is there going to be a change to Gleason 7, which is now = grade 3?
  - A: Gleason 7 will be coded as grade 2 beginning with 2014 cases.

Special Grade System Rules: Prostate

<table>
<thead>
<tr>
<th>Gleason Score</th>
<th>CS Code</th>
<th>Grade Code</th>
<th>AJCC 7th</th>
<th>SEER 2003-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
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<td>G2</td>
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<td>10</td>
<td>010</td>
<td>3</td>
<td>G3</td>
<td>G3</td>
</tr>
</tbody>
</table>

Grade

- Q: If there were multiple invasive tumors, would we code grade based on the higher grade even if it’s the smaller tumor of the two?

- A:
Grade

Q: What about grade for non-invasive papillary urothelial carcinoma? Is there not a special grade system for bladder?

A:

Grade

Q: Should brain be on the list for a special grade system rule? We code the WHO grade as a SSF but don't code it in the grade field.

A:

Grade

Q: What is the grade code if you have a path report for a GE Junction, mucinous adenocarcinoma, histologic differentiation, poorly differentiated, grade 3/4, high grade?

A:
Grade

Q: If you have a well-differentiated bronchiolar adenocarcinoma of the lung, would you follow the terminology grade guidance?

A: Yes.

Grade

Q: Does the instruction regarding assigning grade prior to neoadjuvant treatment only apply to the grade data item?

I was wondering if there was any kind of similar instruction for the data item, lymph vascular invasion.

Grade

Q: For solid tumor grade rule 5 (highest grade even if focus and priority order), which takes precedence - highest grade or priority order? That is, if terminology gives the highest grade and nuclear grade gives a lower grade, what do we use?

A:
Grade

Q: If all we see is FIGO grade 1, 2, 3, do we assign grade code 1, 2, 3, or 9?

A: 

Grade

Q: Does the two-grade system for breast apply to both invasive and in situ tumors?

A: 

Grade

Q: It is my understanding that these new grade coding rules are somewhat "hierarchical". You stop at the first rule that applies. Is this true? Please clarify.

A: 
Lip & Oral Cavity

Collaborative Stage

Pathology Report

- Right subtotal partial inferior maxillectomy with dermal skin graft reconstruction: Right maxillectomy specimen with 1 x 1 x 0.7 cm tumor of upper alveolar ridge, poorly differentiated squamous cell carcinoma, which infiltrates bone and mucoperiosteum of maxillary sinus. All margins of resection are negative for tumor, the closest being the posterior margin at 8 mm.

- Right selective neck dissection: Metastatic squamous cell carcinoma in 2 of 3 lymph nodes, largest metastasis less than 2 cm. There is extracapsular extension in one of the two metastatic nodes.

Collaborative Stage

- What is the code for SSF4 (Levels IV-V & Retropharyngeal Lymph Nodes)?
  a. 000: No involvement in Levels IV or V or retropharyngeal lymph nodes
  b. 100: Level IV lymph node(s) involved
  c. 111: Levels IV & V & retropharyngeal lymph nodes involved
  d. 999: Unknown

- What is the code for SSF3 (Levels I-III Lymph Nodes)?
  a. 000: No involvement in Levels I, II, or III lymph nodes
  b. 100: Level I lymph node(s) involved
  c. 111: Levels I, II & III lymph nodes involved
  d. 999: Unknown
Collaborative Stage

What is the code for SSF5 (Levels VI-VII & Facial Lymph Nodes)?
- 000: No involvement in Levels VI or VII or facial lymph nodes involved
- 100: Level VI lymph node(s) involved
- 111: Levels VI & VII & facial lymph nodes involved
- 999: Unknown

What is the code for SSF6 (Parapharyngeal, Parotid, & Suboccipital Lymph Nodes)?
- 000: No involvement of any group
- 100: Parapharyngeal lymph node(s) involved
- 111: Involvement of 3 groups
- 999: Unknown

Primary Site

Q: Code C14.8 assigned for squamous cell carcinoma diagnosed from lymph node and deemed to be a head and neck primary, but a specific site could not be identified. I assigned code C14.8 based on a note in ICD-O-3 indicating it should be used when a code between C00.0 and C14.2 cannot be assigned.

A: However, an old I & R (46158) indicated it should be coded to C76.0.
Coding Breast Biopsies

Q: How do I code a core biopsy when there is no residual tumor on the subsequent lumpectomy?

A: Coding Breast Biopsies


The Surveillance Epidemiology and End Results (SEER) program instructions for “Surgery of the Primary Site” are consistent:

“Code the most invasive, extensive, or definitive surgery if the patient has multiple surgical procedures of the primary site, even if there is no residual tumor found in the pathologic specimen from the more extensive surgery.”

SEER does not require “Surgical Diagnostic and Staging Procedure” to be coded.

FORDS and SEER

FORDS

- Facility Oncology Registry Data Standards (FORDS) manual, Section One
  - “If surgery of the respective type was performed, the code that best describes the surgical procedure is recorded whether or not any cancer was found in the resected portion.”


SEER

- The Surveillance Epidemiology and End Results (SEER) program instructions for “Surgery of the Primary Site” are consistent:
  - “Code the most invasive, extensive, or definitive surgery if the patient has multiple surgical procedures of the primary site, even if there is no residual tumor found in the pathologic specimen from the more extensive surgery.”
  - SEER does not require “Surgical Diagnostic and Staging Procedure” to be coded.

National Cancer Data Base News

- Both FORDS and the SEER Coding Manual instructions say to code an incisional biopsy as excisional when the margins are microscopically or macroscopically free of tumor.
- Neither SEER nor FORDS instructs registrars to use the pathologic examination from the subsequent surgery (for example, a lumpectomy) to determine whether a preceding biopsy was incisional or excisional.
  - That coding decision depends only on marginal evaluation of the tissue removed in the biopsy.
  - Needle biopsies are not amenable to margin evaluation.

• Only record positive procedures
• Do not code excisional biopsies with clear or microscopic margins

Diagnostic Staging Procedure

Surgical Treatment

• Lumpectomy followed by radiation
• Mastectomy


• Re-excision
• Re-excisions are performed when the patient has a lumpectomy and the entire tumor was not removed.
• Coding a core needle biopsy as an excisional biopsy would artificially inflate the number of re-excisions being done.

Big Picture

• Standard Treatment
  1. Diagnostic staging procedure (02)
  2. Definitive surgical treatment
  3. Adjuvant treatment (if necessary)
• 20 Partial mastectomy, NOS; less than total mastectomy, NOS
• 21 Partial mastectomy WITH nipple reaction
• 22 Lumpectomy or excisional biopsy
• 23 Re-excision of the biopsy site for gross or microscopic residual disease
• 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)
Prostate

Collaborative Stage

- Patient has elevated PSA. Per physician note, DRE is benign. Needle biopsy of prostate: Adenocarcinoma right and left lobes. Per managing physician cT1c. MRI report states the result as cT2c prostate carcinoma.
- What is the code for CS Extension – Clinical Extension?
  a. 150: Tumor identified by needle biopsy (clinically inapparent); Stated as cT1c with no other information on clinical extension
  b. 230: Clinically apparent tumor involves both lobes/sides; Stated as cT2c with no other info on clinical extension
  c. 300: Localized NOS; Confined to prostate NOS; Intracapsular involvement only; Not stated if T1 or T2, clinically apparent or inapparent
  d. 999: Unknown

Collaborative Stage

- Patient has elevated PSA. Tumor involving about a third of the lobe palpated in left prostate lobe on DRE. Needle biopsy of prostate: Adenocarcinoma left lobe.
- What is the code for CS Tumor Size/Ext Eval?
  a. 0: Evaluation based on physical examination including DRE, imaging examination, or other non-invasive clinical evidence
  b. 1: Evaluation based on endoscopy, diagnostic biopsy (needle core biopsy or fine needle aspiration biopsy), TURP or other invasive techniques

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**Note**: preceding codes for Prostate CS Extension – Clinical Extension
Part II CS v02.06

**Note**: preceding codes for Prostate CS Tumor Size/Ext Eval
Part II CS v02.06
Ovary

AJCC TNM Stage

- Debulking path report: High grade serous carcinoma, bilateral ovaries, with peritoneal metastasis beyond the pelvis, largest 2.5 cm; 2/2 mesenteric lymph nodes positive for metastasis.
- How is the mesenteric lymph node involvement coded?
  a. N1
  b. M1


Collaborative Stage

- Final diagnosis: Bilateral ovarian serous carcinoma with liver metastasis. How is the liver metastasis coded in CS?
Histology

Q: Please repeat the difference between GIST NOS and malignant GIST.

A:

Table 1. Risk Stratification of Primary GIST by Mitotic Index, Tumor Size, and Tumor Location

<table>
<thead>
<tr>
<th>Mitotic index</th>
<th>Size (cm)</th>
<th>Site and Risk of Progressive Disease (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 100/50</td>
<td>Low</td>
<td>Low (50)</td>
</tr>
<tr>
<td>&gt; 50 ≤ 100</td>
<td>Low</td>
<td>Low (25)</td>
</tr>
<tr>
<td>&gt; 10 ≤ 50</td>
<td>Low</td>
<td>Low (10)</td>
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<tr>
<td>&gt; 10 ≤ 5</td>
<td>High</td>
<td>High (75)</td>
</tr>
<tr>
<td>&gt; 5 ≤ 2</td>
<td>High</td>
<td>High (50)</td>
</tr>
<tr>
<td>≤ 2</td>
<td>Low</td>
<td>Low (5)</td>
</tr>
</tbody>
</table>

GIST = gastrointestinal stromal tumor; ipf = high-power field, assessed from an area that on initial screen appears to have the highest mitosis activity.

References:
Reportability

- Are there criteria other than a pathologist or clinician’s statement that a registrar can use to determine reportability of gastrointestinal stromal tumors (GIST)?

- Per SINQ 20091021 and 20021151, GIST cases are not reportable unless they are stated to be malignant.
- A pathologist or clinician must confirm the diagnosis of cancer. There are cases that are not stated to be malignant in the pathology report or confirmed as such by a clinician; however, these cases do have information that for other primary sites would typically be taken into consideration when determining reportability. (SEER SINQ 20100014)

Question

- Pathologists have used tumor size and mitotic activity to determine whether GISTS were benign or malignant. The 7th Edition AJCC Manual uses criteria for Stage I GIST which would otherwise be considered benign.
- Could you clarify if we are to go by staging criteria to determine if a GIST is reportable?

Answer

Reportability

- Q: If GIST is benign, why do pathologist stage them? This is confusing since we always assume if cancer is staged, it is malignant.

- A:

Question

- Q: Our cancer committee has decided that we should collect ALL GIST tumors. In the event that a GIST that we have abstracted becomes malignant and thus is now reportable to NCDB, how should this case be handled?

- A:


Reportability

- Q: What if the patient is being treated as malignant even though there is no statement of malignancy (reportability)?

- A:
Bladder

### Stage
- TURB pathology: Bladder cancer in lateral wall; 1 cm urothelial carcinoma that invades the superficial muscularis propria.
- Cystectomy: In situ urothelial carcinoma of bladder.

### Collaborative Stage

**What is the code for CS Extension?**
- a. 060: Nonpapillary – Sessile CA in situ, CA in situ NOS, transitional cell CA in situ
- b. 210: Muscle of bladder only; superficial muscle - inner half
- c. 220: Muscle of bladder only - deep muscle - outer half
- d. 240: Muscle invaded NOS of bladder only

**What is the code for CS Tumor Size/Ext Eval?**
- a. 0
- b. 1
- c. 3
- d. 9
AJCC TNM Stage

- What is the directly coded AJCC clinical T category?
  a. X: Primary tumor cannot be assessed
  b. Tis: CA in situ – flat tumor
  c. T2: Tumor invades muscularis propria
  d. pT2a: Tumor invades superficial muscularis propria

- What is the directly coded AJCC pathologic T category?
  a. X: Primary tumor cannot be assessed
  b. Tis: CA in situ – flat tumor
  c. T2: Tumor invades muscularis propria
  d. pT2a: Tumor invades superficial muscularis propria

Melanoma

Collaborative Stage/Surgery Data Items

- Q: If patient has 1 lymph node positive for melanoma and primary skin site cannot be identified, how should the following fields be coded?
  - CS Lymph Nodes:
  - Regional Nodes Positive:
  - Regional Nodes Examined:
  - Scope of Regional Lymph Node Surgery:
  - Surgical Procedure/Other Site:
Collaborative Stage - LDH

- Q1: What is the code for SSF4 [Serum Lactate Dehydrogenase (LDH)] if the 1st LDH test is negative and 2nd test was unknown?
  - A1:

- Q2: What is the code for SSFS (LDH Lab Value) if 1st test is positive and 2nd test is negative?
  - A2:

Question

- It came to our attention while reviewing the changes to the SEER Program Manual for 2014, that a new coding instruction was added to the Surgery of Primary Site section. I was hoping you could help clarify how this affects coding.
  - The new statement added says, “Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed and margins are clear.” This was statement was not included in the SPCM 2013

Shave Biopsy
Surgical Diagnostic Staging Procedure

- If the tumor is very large or in a site that is difficult to biopsy, the physician may choose to take a small sample of the tumor rather than remove the entire tumor.
  - If this is done, the margins on the specimen sent to pathology will be grossly positive.
  - This would be coded as a Surgical Diagnostic Staging Procedure code 02.

Excisional Biopsy

- If a physician suspects melanoma, they will probably try to remove the entire lesion. This may be done as a standard excisional biopsy, punch biopsy, or a shave biopsy.
  - Regardless of the approach, this procedure should be coded using the surgery code 27.
  - If the margins of the biopsy are microscopically positive or there is no information about the margins, assume it was an excisional biopsy.
  - The surgeon will attempt to take 3-5mm of healthy tissue and will try to minimize damage to the lymphatics.

Wide Excision

- Following the excisional biopsy the patient will probably have a wide excision.
  - A wide excision removes a margin of healthy tissue from around the melanoma site.
  - If a sentinel lymph node biopsy is recommended, it will be done prior to the wide excision.
Wide Excision

- If the margin of healthy tissue is 1cm or less, code this procedure using codes 30-33.
- Codes 30-33 would also be used if the margin of healthy tissue is not stated.
- Even though these codes reflect two procedures, the date of surgery when assigning codes 30-33 is the date of the wide excision.

Applies only if you facility can code multiple surgical events. If you can only code one surgical event, use the code for the first one and use the code for the most definitive event.

Wide Excision

- Code 30 is used if the original excisional biopsy was a standard excisional technique or if the technique was not indicated.
- Code 31 is used if the original excisional biopsy was a shave biopsy.
- Code 33 is used if the original biopsy was incisional and then a wide excision was done (the incisional biopsy was coded as a diagnostic staging procedure).
- If your facility only codes one surgery for each abstract (i.e. hospital only reporting to the state cancer registry), use the code for the most definitive procedure.

Wide Excision

- Code 45 is used if the patient has a wide excision and the margins are more than 1cm, but it is not documented if they are more or less than 2cm’s.
- Code 46 is used if the patient has a wide excision and the margins are more than 1cm and it is documented that the margins are equal to or less than 2cm’s.
- Code 47 is used if the patient has a wide excision and the margins are more than 2cm’s.
**Wide Excision**

- When a wide excision with 1-2cm margins is performed (code 46), followed by re-excision for wider margins:
  - If the total combined resection margins are >2cm, use code 47
  - If no information is available of the path report does not describe the distance from the margins to the previous spot, code the re-excision as 46 (two entries with surgical code 46)

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**Answer**

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**Hematopoietics**
Hematopoietics-Transformations

- Transformations to
  - Acute or more severe neoplasm
- Transformations from
  - Chronic neoplasm
- Examples
  - Essential thrombocythemia (9962/3)
    - Transformations to: Acute myeloid leukemia (9861/3)
  - Plasma cell myeloma (9732/3)
    - Transformations from: Solitary plasmacytoma of bone (9731/3)

Colon & Rectum

Treatment

Q: Please address staging polypectomies. Is polypectomy, then chemotherapy, lastly hemicolectomy considered neoadjuvant treatment?

A:
**Anatomy**

*Q:* When a tumor extends into the subserosa, isn’t that considered pericolonic fat?

*A:* Subserosal Fat

**Histology**

*Q:* If you had an adenocarcinoma with mucinous features how would you code the histology?

http://seer.cancer.gov/seerinquiry/index.php?page=quick_search&topic1=&topic2=&topic3=&start_year=2000&end_year=2014&quicksearch=20071122&question_id=&cat_andor=AND&cat0=+&cat1=+&cat2=+&last_update=&free_andor=AND&free0=&free1=&free2=&free3=&asc_yr_text=&Question_1=1&Question_3=1&search_display_format=1
Histology

Q: What is the histology code of a mucinous adenocarcinoma in a polyp?

A: 79

Anatomy

Q: Would you say the basement membrane is before the lamina propria, and once a tumor invades the lamina propria it is local stage?

A: Yes

Collaborative Stage

Patient had routine colonoscopy with polypectomy which diagnosed adenocarcinoma. Hemicolectomy was performed a month later, and there was no residual malignancy. CEA was drawn after the polypectomy but before the resection. The results were 7 ng/ml with normal being <5.
Collaborative Stage

What is the code for SSF3 (Carcinoembryonic Antigen (CEA))?  
- 050: Positive/elevated  
- 070: Negative/normal  
- 998: Test not done  
- 999: Unknown

AJCC TNM

Q: Patient has polypectomy. Path shows that the polyp is purely in situ, and there is no residual tumor. Can we pathologically stage this cancer?  
A:
### AJCC TNM Stage

- MRI: Hepatomegaly; 7 cm right liver lobe mass with intrahepatic metastases in both lobes and vascular invasion; small hepatic nodes; no other organomegaly. Liver is cirrhotic.
- Hepatic biopsy: Hepatocellular carcinoma, grade 3.

### AJCC TNM Stage

- What is the clinical T?
  - a. TX: Primary tumor cannot be assessed?
  - b. T2: Solitary tumor with vascular invasion or multiple tumors none more than 5 cm
  - c. T3a: Multiple tumors more than 5 cm
  - d. T3b: Single tumor or multiple tumors of any size involving a major branch of the portal vein or hepatic vein

- What is the pathologic T?
  - a. TX: Primary tumor cannot be assessed?
  - b. T2: Solitary tumor with vascular invasion or multiple tumors none more than 5 cm
  - c. T3a: Multiple tumors more than 5 cm
  - d. T3b: Single tumor or multiple tumors of any size involving a major branch of the portal vein or hepatic vein

### Lung
**Histology & Behavior**

- **Q:** Is bronchioalveolar carcinoma considered in situ?
  - **A:**

**Topography**

- **Q:** What is the ICD-O site code for “infra hilar” tumor?
  - **A:** Per “Ask a SEER Registrar”
    Assign code C349 when infra hilar refers to the infra hilar area of the lung and no further information is available.
    - See #12 on page 67 in the SEER manual,

**Collaborative Stage**

- **Q1:** Please define pleural based mass.
  - **A1:**

- **Q2:** Is the CS Extension code for a pleural based mass with no other statement of invasion 410?
  - **A2:**

**Collaborative Stage**

- Right lung cancer with right pleural effusion; single negative cytology of pleural effusion but fluid is exudative and bloody.
- What is the code for CS Mets at DX?
  - a. 00: No distant metastasis
  - b. 15: Malignant pleural effusion, ipsilateral or same lung
- What is the code for CS Mets Eval?
  - a. 0: Evaluation of distant metastasis based on non-invasive clinical evidence
  - b. 3: Specimen from metastatic site microscopically positive

**AJCC TNM Stage**

- How would you code the T category for invasion of primary lung tumor into rib?
  - a. T3: Tumor more than 7cm or one that directly invades: parietal pleura chest wall, diaphragm, phrenic nerve, mediastinal pleura, parietal pericardium; or tumor in main bronchus; or associated atelectasis or obstructive pneumonitis of the entire lung or separate tumor nodules in same lobe
  - b. T4: Tumor of any size that invades: mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, esophagus, vertebral body, carina, separate tumor nodules in different ipsilateral lobe

**Questions?**
Coming Up...
- Registration is open for 2014-2015 Cancer Registry & Surveillance Webinar Series

And the winners are......

CE Certificate Quiz/Survey
- Phrase
- Link
  -
Thank You!!!!

Please send any questions to:
Jim Hofferkamp hofferkamp@naaccr.org
Shannon Vann svann@naaccr.org

Thank You!!!!